

US Army MEDDAC-Japan
BG Crawford F. Sams US Army Health Clinic

PERIODIC HEALTH ASSESSMENT
- Questionnaire -

<p>1. Name: _____ SSN: _____</p> <p>Date of Birth: _____ Age: _____ Gender: <u>Male / Female</u></p> <p>Work phone: _____ Home phone: _____</p> <p>e-mail address: _____ Today's date: _____</p>	For Provider only
<p>2. a. Do you currently need or take prescription medicines, vitamins, birth control pills, food supplements, herbs or over the counter medicines?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. If yes, list all medications you are taking. (Please bring all medications to your PHA appointment.)</p>	
<p>3. List any ongoing medical problems.</p>	
<p>4. List all surgeries and overnight hospital stays.</p>	

<p>5. Are you currently in good health?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>For Provider only</p>																				
<p>6. Has a health care provider ever told you that you have any of the following conditions? Please check a box on each line.</p> <table border="0"> <tr> <td><u>High blood pressure</u></td> <td><u>Lower back pain</u></td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><u>High cholesterol</u></td> <td><u>Depression</u></td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><u>Heart disease or angina</u></td> <td><u>Anxiety</u></td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><u>Asthma</u></td> <td><u>Cancer</u></td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><u>Diabetes</u></td> <td><u>Thyroid</u></td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	<u>High blood pressure</u>	<u>Lower back pain</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>High cholesterol</u>	<u>Depression</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Heart disease or angina</u>	<u>Anxiety</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Asthma</u>	<u>Cancer</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Diabetes</u>	<u>Thyroid</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>High blood pressure</u>	<u>Lower back pain</u>																				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
<u>High cholesterol</u>	<u>Depression</u>																				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
<u>Heart disease or angina</u>	<u>Anxiety</u>																				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
<u>Asthma</u>	<u>Cancer</u>																				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
<u>Diabetes</u>	<u>Thyroid</u>																				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
<p>7. Are you <u>limited or prevented</u> in any way in doing things most people can do (<u>for example</u>: work, go to school, do housework, socialize, cook, do paperwork)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>																					
<p>8. If you are military, do you currently have a profile? If yes, bring a copy of your profile to your PHA appointment.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>																					
<p>9. a. Have you ever been deployed?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. If yes, when and where?</p> <p>Date: _____ Place: _____</p>																					
<p>10. a. Do you use tobacco products?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. If yes, please answer the following.</p> <table border="0"> <tr> <td><u>Cigarettes</u></td> <td></td> </tr> <tr> <td>How many:</td> <td>How long:</td> </tr> <tr> <td><u>Cigar</u></td> <td></td> </tr> <tr> <td>How many:</td> <td>How long:</td> </tr> <tr> <td><u>Pipe tobacco</u></td> <td></td> </tr> <tr> <td>How many:</td> <td>How long:</td> </tr> <tr> <td><u>Smokeless tobacco (chew, snuff)</u></td> <td></td> </tr> <tr> <td>How many:</td> <td>How long:</td> </tr> </table>	<u>Cigarettes</u>		How many:	How long:	<u>Cigar</u>		How many:	How long:	<u>Pipe tobacco</u>		How many:	How long:	<u>Smokeless tobacco (chew, snuff)</u>		How many:	How long:					
<u>Cigarettes</u>																					
How many:	How long:																				
<u>Cigar</u>																					
How many:	How long:																				
<u>Pipe tobacco</u>																					
How many:	How long:																				
<u>Smokeless tobacco (chew, snuff)</u>																					
How many:	How long:																				

<p>19. For males: Do you perform self-testicular exams monthly?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For females: Do you perform self-breast exams monthly?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>For Provider only</p>
<p>20. A Pap smear is a test for females only. How long has it been since you had your last Pap Smear?</p> <p><input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1 year ago <input type="checkbox"/> 2 years ago</p> <p><input type="checkbox"/> 3 or more years ago <input type="checkbox"/> Never <input type="checkbox"/> Don't know</p>	
<p>21. In the <u>past year</u>, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>22. How long has it been since you last visited a dentist or other dental health professional for a routine checkup or cleaning?</p> <p><input type="checkbox"/> Within the past 12 months <input type="checkbox"/> More than 1 year ago</p>	

Patient's Signature: _____

Date: _____

Provider's Signature: _____

Date: _____